TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding RX

Respondent Name
Merged Royal Insurance Co of America
Into Arrowood Indemnity

MFDR Tracking Number
M4-16-1124-01

Carrier's Austin Representative
Box Number 11

MFDR Date Received
December 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached bills were denied by the carrier stating preauthorization was not obtained."

Amount in Dispute: $996.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Arrowood Indemnity (Royal Insurance Co of America) obtained prospective reviews of the compounded prescription medication from Prium on two occasions. …Both prospective reviews were adverse."

Response Submitted by: Arrowpoint Capital

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 15, 2015	Bupivicaine HCL, Cyclobenzaprine HCL, Flurbiprofen, Meloxicam, Tramadol	$498.15	$325.46
January 29, 2015	Bupivicaine HCL, Cyclobenzaprine HCL, Flurbiprofen, Meloxicam, Tramadol	$498.15	$325.46
		$996.30	$650.92

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the pharmacy reimbursement guidelines.
3. 28 Texas Administrative Code §134.530 sets out requirements for use of the closed formulary for claims not subject to certified networks.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 39 *I – Services denied at the time authorization/precertification was requested.

Issues

1. Is the respondent's position statement supported?
2. Is the denial for Cyclobenzaprien HCL and Tramadol supported?
3. What is the applicable rule pertaining to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute is related to the five prescription drugs Bupivicaine HCL, Cyclobenzaprine HCL, Flurbiprofen, Meloxicam, Tramadol. The dates of service for these medications are January 15, 2015 and January 29, 2015. The respondent states in their position, "Arrowood Indemnity (Royal Insurance Co of America) obtained prospective reviews of the compounded prescription medication from Prium on two occasions. …Both prospective reviews were adverse."

28 Texas Administrative Code §134.530 (b) states,

(1) Preauthorization is only required for:

(A) drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates;

(B) any compound that contains a drug identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates; and

(C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

Review of the Appendix A, ODG Workers' Compensation Drug Formulary finds none of the medications in dispute are Status "N" drugs. Nor are any classified as investigational or experimental. Preauthorization was not required. However, the requirements of Rule 134.530(g) is discussed below.

28 Texas Administrative Code §134.530(g) states,

Retrospective review. Except as provided in subsection (f)(1) of this section, drugs that do not require preauthorization are subject to retrospective review for medical necessity in accordance with §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) and §133.240 of this title (relating to Medical Payments and Denials), and applicable provisions of Chapter 19 of this title.

(1) Health care, including a prescription for a drug, provided in accordance with §137.100 of this title is presumed reasonable as specified in Labor Code §413.017, and is also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a).

(2) In order for an insurance carrier to deny payment subject to a retrospective review for pharmaceutical services that are recommended by the division's adopted treatment guidelines, §137.100 of this title, the denial must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established under Labor Code §413.017.

Evidence was found to support a Retrospective Review as described in Rule 134.530 (g) was done for the medications in dispute submitted as Flurbiprofen, Meloxicam, and Bupivacaine. However the medications, Tramadol and Cyclobenzaprine HCL were not reviewed per the submitted report.

The respondent's position statement is supported for Flurbiprofen, Meloxicam, and Bupivacaine and subject to Rule 134.503(g), the services in dispute were reviewed retrospectively by Prium Medical Cost Management Services and a "Adverse Determination" was made . No additional payment can be recommended for these medications.

2. The remaining medications in dispute are Tramadol and Cyclobenzaprine HCL. The carrier denied with the remark code, #39: *I – "Services denied a the time authorization/pre-certification was requested". As discussed above, review of the Appendix A, ODG Workers' Compensation Drug Formulary finds none of the medications in dispute are Status "N" drugs. Nor were any classified as investigational or experimental. Preauthorization was not required. The carrier's denial for these medications is not supported. These medications will be reviewed per applicable rules and fee guidelines.

3. 28 Texas Administrative Code §134.503 (c) states,

> The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
>
> (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
>
> (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
>
> (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;
>
> (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection;

The maximum allowable reimbursement will be calculated as follows;

Date of Service	Medication	Quantity	AWP	MAR
January 15, 2015	Tramadol HCL	6	$36.30	$36.30 x 6 units = $217.80
January 15, 2015	Cyclobenzaprine HCL	2	$46.33200	$46.33200 x 2 units = $92.66
January 15, 2015	Compounding fee	1		$15.00
January 29, 2015	Tramadol HCL	6	$36.30	$36.30 x 6 units = $217.80
January 29, 2015	Cyclobenzaprine HCL	2	$46.33200	$46.33200 x 2 units = $92.66
January 29, 2015	Compounding fee	1		$15.00
			TOTAL	$650.92

4. The maximum allowable reimbursement for the services in dispute is $650.92. The carrier previously paid $0.00. The remaining balance of $650.92 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $650.92.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $650.92 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		January 13, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.